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Division of Health Care Financing
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TO: Medicaid Eligibility Handbook Holders

FROM: Cheryl McIlquham, Director
Bureau of Health Care Eligibility

RE: Medicaid Eligibility Handbook Release 05-01

DATE: January 11, 2005

The changes noted in this cover sheet are incorporated into the online handbook. Changes are indicated with yellow highlighted text. Anytime you access the online MEH, it will reflect current policy. To be notified of MEH releases by email, go to http://dhfs.wisconsin.gov/em/policy-notification/signup.htm, enter your email address and check the "Medicaid" box in the "notification listing" section.

EFFECTIVE DATE — Release and effective dates are at the bottom of each web page within the MEH.

The following changes are included in this release:

CHANGES

1.1.2.1 — Clarification was provided that Family Planning Waiver Program applicants/recipients should not be sanctioned for being on strike.

New Text

In addition to the non-financial requirements listed in 1.1.2, a client applying for Family MA must not be on strike (3.4). Do not sanction anyone on strike who is pregnant, a minor, over age 65, blind or disabled, on a MA extension **or a Family Planning Waiver Program applicant/recipient.**

1.1.3.1.2 Examples explaining how/when assets should be deemed to a disabled minor were added to the asset section of the Financial Tests for Disabled Minor section.

New Text

Example 1: A single parent with a disabled minor owns $4500 in nonexempt assets. $2500 of that asset would be deemed to the disabled minor when determining that minor's Medicaid eligibility.

Example 2. A parent and his/her spouse own $4500 in non-exempt assets. The parent has a disabled minor child. $1500 of the parent's and the spouse's assets would be deemed to the disabled minor when determining the minor's Medicaid eligibility.

1.2.3.4 Verification requirements for incapacitation were removed. Operations Memo 03-45 changed the unemployed parent policy. As of August 1, 2003 as long as there is non-financial eligibility, two parent families are assessed for MAU and MAOU based on their income, just as one parent families are for MAR/MAOR.

Old Text

~~Incapacitation. Verification of incapacitation is mandatory when incapacitation is the reason for a deprived child. Inform a client who is incapacitated that s/he must have the Medical Examination and Capacity Form (DES 2012) completed by a medical professional. Instruct him/her to fill out a Confidential Information Release Authorization – Disability Determination Bureau form (HFS-9D) and return to you.~~

~~You may presume incapacitation when you have reliable information received by phone from a physician, hospital, chiropractor, or public source like a newspaper. You may also presume incapacitation if a parent gets Workers' Compensation or private disability insurance benefits. Verify the presumed incapacitation within sixty days.~~

2.1.3.1.1 A new section was added regarding the role of the Durable Power of Attorney in the application process.

New Text:

A client's Durable Power of Attorney may appoint an authorized representative for purposes of making a Medicaid application if authorized on the power of attorney form. The Durable Power of Attorney form will specify what authority is granted.

The appointment of a Durable Power of Attorney does not prevent a

client from filing his/her own application for Medicaid nor does it prevent the client from granting authority to someone else, to apply for public assistance on his/her behalf.

2.2.1.1.7, 2.2.1.1.8 New Backdating procedures and policies for Wisconsin Well Woman Medicaid clients were incorporated into the Handbook. This policy was originally communicated in Operations Memo 04-31.

3.1.4.4 , 5.3.3 Clarification was provided on eligibility for Non-IV E foster children.

New Text

Non IV-E foster children are automatically eligible for Medicaid. These cases are certified manually outside of CARES.

3.5.6 Children in IMDs for more than 30 days may be considered temporarily absent.

New Text :

A child may be considered temporarily absent, and remain in the caretaker's AFDC- Related or AFDC- MA group, when s/he is placed in non-Title IV-E Foster Care, Kinship Care, or a group home.

Children who are inmates of public institutions are not temporarily absent.

Children who are placed in an institution for 30 or more days are not temporarily absent, unless they were placed there by a child welfare agency.

Children who are placed in an IMD are not temporarily absent, unless they were placed there by a child welfare agency.

3.6.3.1 Clarification was provided for when disability re-determinations are required for recipients who are not on SSI or SSDI.

Disability re-determinations are required on the diary date for recipients who are not on SSI or SSDI**.**

3.6.8 The Presumptive Disability policy was modified to reflect policy communicated in Operations Memo 03-06.

4.1.3.1 Clarification was provided on deductions for maintaining a home for institutional cases.

New Text

The home maintenance allowance can be granted at any time as long as the person is institutionalized. It is not limited to the first six months of institutionalization.

Example: Bob was institutionalized in June 2003 as a private pay patient. In June 2004, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2004. He is eligible for the deduction from his income when determining the amount of his income available for his cost of care starting in June 2004.

4.1.3.2.1 An example was added to clarify how to account for payment history when budgeting court ordered child support payments.

New Text

Example: In 2000, George was ordered to pay $500 per month in child support for his son Rosco. In February 2002, George had a car accident and has since been placed in a nursing home where he is recuperating. George has not made a child support payment since November 2002.

George submitted an application in November 2003. Since George has not made a child support payment in over a year, do not include child support payments in his eligibility determinations.

4.1.4.1 Clarification was provided that all payments made from trusts to the beneficiary are unearned income to the beneficiary. This includes payments made directly to vendors for services provided to the beneficiary. Examples include payments from the trust to a landlord for rent, to a utility for electricity, or to the telephone phone company for the beneficiaries telephone service.

4.1.6.1.2 Clarification was provided on prorating income.

Old Text
Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, ~~**may**~~ be converted to a monthly amount or prorated

New Text
Income received on a yearly basis or less often than monthly, that is predictable in both amount and frequency, **must** be converted to a monthly amount or prorated.

4.5.2 New language was added to clarify availability of assets in backdate months.

4.5.5.2 The section on burial insurance was updated to reflect the clarification communicated in Operations Memo 04-28.

4.5.7.11.1 **New Text**

The unspent portion of retroactive SSI and RSDI benefits received on or after March 2, 2004 is excluded from resources for the 9 calendar months following the month in which the individual receives the benefits.

Do not count a retroactive social security or SSI payment as an asset either in the month of receipt or 9 months following the month the payment is received. A retro-active payment means it is paid later than the month in which it is due. After 9 months, treat any remaining available portion as an asset.

During the nine months in which it is not counted, the unspent portion of the payment can be mingled with other funds, provided it can be distinctly and separately identified.

The unspent portion of retroactive SSI and RSDI benefits received be fore March 2, 2004 is excluded from resources for the 6 calendar months following the month in which the individual receives the bene fits.

4.5.7.21 The disregard of work-related retirement plans when determining the amount of countable assets of an ineligible spouse, also applies to the ineligible parent or parents of a disabled child.

4.5.8.1 The Definition of “Homestead Property” was clarified for farm property.

New Text

Land should be considered part of the home property if it is not completely separated from the home property by land, in which neither the individual nor his/her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc) do not separate other land from the home plot.

If land is completely separated from the home property by land, in which neither the individual nor his/her spouse has ownership interest, it should not be considered part of the homestead property.

4.9.3 A reminder was placed in the text that CARES does not send a review notice to the client when s/he has not met a deductible.

4.9.8 The subsection on what costs could be used to meet a deductible was re-organized. Some, but not all, of the clarifications made in this sub section are listed below.

4.9.8.1 Clarification and an example were provided on how to treat deferred charges.

New Text

Note: Charges that are in deferred status cannot be used to satisfy a deductible unless the provider bills the client or provides a write-off date.

Example:

From May- July 2003 Helen resided in an Institute for Mental Disease (IMD) and incurred a $14,000 bill. As of October 2004, Helen has not paid this bill. In October Helen's social worker, Ruth, applies for MA on Helen's behalf.

Ruth tried to help Helen meet her deductible by collecting Helen's medical bills. The "bill" for Helen's IMD stay listed $ 14,000 in "Deferred Charges". Ruth questioned what deferred meant. The account's receivable person at the IMD indicated that charges for low-income people are often "deferred." "Deferred", she explained, means that the client would never be billed for the charges, but if s/he happens to come into a windfall of money (lottery or inheritance), they will change the status of those charges to current and try to collect the debt.

Helen can not use this "deferred" charge toward her deductible. Charges in deferred status cannot be used to satisfy a deducible unless the provider bills the client, with an expectation that they will pay the bill or, provides a write-off date.

4.9.8.1 Text was deleted regarding verification requirements for medical costs incurred more than 6 months prior to the application date. Medical expense for meeting a deductible must be verified regardless of the date the medi

cal costs were incurred.

Old Text

~~**Note:** Applicants must submit documentary proof of liability for medical costs incurred more than six months prior to the date of application.~~

4.9.8.1.1 Clarification was provided on when medical services or prescriptions provided outside the United States can be counted toward a deductible.

New Text

Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

4.9.8.2 #3 Medical expenses paid by Medicaid/Medicare may not be counted toward a deductible.

Old Text

~~Do not count the following toward the deductible:~~

~~3. Medical services payable or paid for by a third party who is legally liable at any time during the deductible period.~~

New Text

Do not count the following toward the deductible:

3. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare or other Insurance.

4.9.8.2 #3 Clarification was made that payments for recipients made by the AIDS Drug Assistance Program (ADAP) are a countable cost toward a recipient's deductible.

4.9.8.2 #4 Clarification was provided on using past medical bills toward a deductible.

Old Text

~~A bill cannot be counted if it has been used to meet a prior deductible.~~

New Text

A bill cannot be counted if it has been used to meet a prior deductible. If only a portion of an unpaid bill has been used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, can be applied to a subsequent deductible period.

4.9.13.3 New language was added to clarify how to treat changes that effect non-financial eligibility after the deductible has been met.

New Text

If a client loses non-financial eligibility and regains it during the same deductible period, the client may choose:

- **to be re-certified for the remainder of the deductible period**

OR

- **to reapply and establish a new deductible period if his or her income still exceeds the appropriate Medicaid income limit.**

5.7.1.3 The definition of BadgerCare (BC) recipients was clarified:

Old Text:
BC recipients are those ~~that have been eligible in the current of previous month for BC.~~

New Text:
BC recipients are those **who are eligible for and receiving BC in the current or previous month.**

5.7.3.4 WisconCare was discontinued effective 07/25/03 with the 2003/2005 Budget Bill.

5.7.3.4.1 A reference to an IRS form was corrected.

5.8.5 **New Text**

Prepayment to a nursing home for the extra cost of a private room is an available asset. The applicant has the legal ability to make the prepayment available for his/her support and maintenance.

5.10.6 The Standard Utility Allowance was updated to reflect new allowances in spousal impoverishment cases for heating, utilities and telephone. The changes were originally communicated in Operations Memo 04-45.

5.12.3.4.1 References to the HEC consumer guide have been replaced by a link to the Medicaid Purchase Plan Fact-sheet (PHC 10071.)

5.12.4.1.1 **MAPP Independence Accounts** policy was clarified in regards to withdrawals from Independence Accounts.

5.16.3.1.1 Clarification was made on refunds for SeniorCare opt out-cases.

Old Text

In all opt-out cases, a refund will be issued only if the request to withdraw from the SC program is ~~**made**~~ by the later of:

New Text
In all opt-out cases, a refund will be issued only if the request to withdraw from the SC program is **received** by the later of:

- Ten days following issuance of the eligibility notice, or
- 30 days from the application filing date.

5.16.12.1 Clarification was made on when SeniorCare opt out requests.

5.17.2.2 An additional criteria was added to Non-Disqualifying Insurance Coverage.

New Text

g. Non-coverage of cancer treatment due to waiting period.

5.17.2.3 Policy communicated in Operations Memo 04-31 was incorporated into the MEH.

New Text

Women enrolled in Family Planning Waiver who meet the following criteria, (regardless of age) will be eligible for Wisconsin Well Woman Medicaid. These are woman who:

- **Are screened for, and diagnosed with, cervical cancer or a pre-cancerous condition of the cervix,**

  OR

- **Receive a clinical breast exam through FPW and through follow up medical testing independent of the FPW are diagnosed with breast cancer.**

  AND

- **Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition and do not have other insurance that would cover the cancer treatment.**

5.17.6.1 The application process was described for Family Planning Waiver Program participants applying for Wisconsin Well Woman Medicaid Program.

5.17.8 Clarification was provided on reviews for Wisconsin Well Woman Participants.

5.18.1 The Caretaker Supplement (CTS) Handbook was issued on December 20, 2004. The CTS Handbook is now available at the following web-site: http://dhfs.wisconsin.gov/ssi/CaretakerHandbook/index.htm

6.2.1.1 The Definition of fraud was changed to reflect the definition found in state statutes.

Old Text

~~Fraud occurs when a client intentionally omits or provides erroneous information at the time of application or review.~~

New Text

Fraud exists when an applicant, recipient or any other person responsible for giving information on the client's behalf does any of the following:

1. **Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.**

2. **Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.**

3. **Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.**

4. **Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something**

other than the intended use and benefit of such persons listed on the application.

8.1.5, 8.1.5.1, 5.10.4.2, 5.11.7.2	Sections of the handbook were updated to reflect the 2004 Cost of Living Adjustment effective January 1, 2005. These changes were originally communicated in Operations Memo 04-60.
8.1.2	The Life Estate and Remainder Interest Table has been replaced with a new process that allows the latest applicable interest rate to be used in a client's valuation.
8.1.5.1	A $65 Personal Needs allowance for PACE/partnership participants who reside in a CBRF was added to the EBD deductions and allowances table.
8.1.7	The COLA disregard table was updated with 2005 numbers. The COLA disregard table placed in the handbook in release 04-03 had incorrect numbers. For historical purposes the 2004 COLA disregard table with the correct 2004 numbers can be found by clicking on the view history link in 8.1.7. Use the 2005 COLA disregard table for future disregard amounts.
Minor Changes	**Obsolete form references were replaced in 3.6.2 and 1.2.9**